Exhibit 2

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EDITED TRANSCRIPT

HTWR - HeartWare International at William Blair & Company LLC Growth Stock Conference

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THOMSON REUTERS

CORPORATE PARTICIPANTS

Doug Godshall *HeartWare International, Inc. - Executive Director, President & CEO*

CONFERENCE CALL PARTICIPANTS

Matt O'Brien *William Blair & Co. - Analyst*

PRESENTATION

Matt O'Brien - *William Blair & Co. - Analyst*

Good afternoon, everybody. This is Matt O'Brien from William Blair, I cover medical technology here. I'm joined by my associate as well, Kayla Crum. Next and last, but certainly not least, on the agenda is HeartWare. From the Company is Doug Godshall, CEO as well as Chris Taylor, the VP of IR or Manager and Director of IR, one of the two. But just real quickly a couple formalities. The breakout session actually will be in this room after the formal presentation. I would ask everybody from a disclosure perspective to check the website www.williamblair.com for any and all disclosures that we have on HeartWare. So, I will stop there and go ahead and turn it over to Doug Godshall.

Doug Godshall - *HeartWare International, Inc. - Executive Director, President & CEO*

Thanks, Matt and Kayla, for inviting us and to all of you for making it through the day and listening to the story of HeartWare. Just as Matt was giving you his disclosure, we are obviously going to be making multiple forward-looking statements and I encourage you to read our Safe Harbor.

HeartWare is certainly expanding our global presence. We have over 5,000 implants in our history, we're in over 100 centers in the US, pushing 150 outside the United States, we are now in 37 countries, and well north of 500 employees. At this juncture in the United States, we have implanted over 1,500 implants or pump patients. And to date our longest running survivor is over six-and-a-half years and the gentleman pictured below there in Perth, Australia hopefully remains very happy. And it's encouraging to see the number of patients who are now clearing the four or five and six-year mark on our system when one thinks back that our first implant was in 2006 and a very small number of patients that year. It's encouraging to see that we're getting nice long survival benefit for these patients.

For those of you less familiar with our system. The HVAD is a very small rotary pump, it's placed in the pericardium which is the area right adjacent to the heart. And while it's very small, it also provides full support. Nobody really needs 10 liters, but the pump can deliver up to 10 liters, our patients average about five to six liters. The impeller is levitated using a combination of magnets and what's called a hydrodynamic thrust bearing. So the thrust bearing basically enables the blood to serve as a cushion between the impeller, which spins at about 3,000 revolutions per minute, and the housing so that there's no friction between the magnetic and hydrodynamic levitation. This combined suspension mechanism without mechanical bearings enables full washing of all the surfaces of the impeller and the housing.

The pump is connected to an external controller or computer and batteries through a thin durable flexible driveline. Graphically looking at our implant history. In red is our international implants over time since approval in 2009 and in blue is our US implant rate. And as you can see, we had variability in the United States up until we received approval at the end of 2012 and the impact of pre-approval and post approval is quite evident in our implants in 2013 where we saw a meaningful step up and basically 40% of our total implants occurred in that one year. We were flattered by the positive response we saw in the first quarter of 2014 and while we certainly don't run our business with a quarterly focus, it's always encouraging to see positive trends on a quarter-to-quarter basis as we saw early this year and certainly hope to continue it.

Looking at a map of the US, on one hand the VAD centers somewhat mimic the population, but clearly there's a skew towards the East Coast. We're working hard to expand adoption on the West Coast. We're starting to see some nice traction in centers in California and yet there is meaningful upside really in all major geographies, none of these centers really feel tapped out. One thing that has been interesting is to see a growing use of our device in pediatric sites. And while we don't market for pediatric, that's off label, it is a very significant top of conversation at every pediatric heart failure meeting is now the HeartWare device for peds.

Internationally, we are also honored to be sort of the VAD of choice over the past couple of years. We have been the most implanted VAD for well over 24 months now and are encouraged and frankly surprised that we continue to see such a rapid expansion of trial sites. We keep beating our own expectations with 12 new centers added in the first quarter of last year, half of which were brand new VAD centers and half of which were competitive sites that used other VADs. Another graphic just showing our overall revenue not implants, but obviously maps to our implant total and then a very strong revenue quarter of $66.5 million with a good cash position of $181 million.

On the clinical trial front, there are really two indications in the United States; bridge-to-transplant and Destination Therapy. Outside the United States while we have bridge-to-transplant indication, physicians and payers are little less indication centric versus in the US where they really latch on to bridge-to-transplant. And the name kind of probably makes sense, you put a VAD in a patient who is waiting for a transplant and won't live long enough to get the transplant so you're bridging them to the transplant. Destination Therapy, these are patients who aren't eligible for transplant or aren't listed; you put the pump in and they're going to rely on a pump for the duration of their life, which is hopefully a very long life.

The bridge-to-transplant trials have been running although we are now following our patients in a post-approval study of 600 patients. Destination Therapy, we have two arms. We have the original arm and the two-year end point was reached this past month and we will be calculating our primary endpoint at the end of this year and presenting the data early next year. The second cohort of endurance is what we're calling a supplemental cohort looks at managing patients' mean arterial pressures or blood pressures a little bit more rigorously because what we saw in the first cohort is when patients have high blood pressure, they also seem to have more neurologic events, specifically hemorrhagic strokes.

And so what we wanted to demonstrate is that if we reduce pressures, on a prospective basis do we see reduced neurologic events. And in all of our multivariate analysis, blood pressure keeps coming up as the real risk factor and so we're really interested in seeing this cohort, which is currently enrolling, to see if on a prospective basis we can confirm what we have seen retrospectively. In terms of the trials that have been enrolled, this is a representation of our HVAD clinical experience both bridge and Destination Therapy. Again, the largest cohort is in this post-approval study, which we saw early returns on at the International Society of Heart & Lung Transplant back in April and we saw some very encouraging trends of this commercial experience.

We are also in the midst of our first clinical trial in Japan, which we anticipate will be a very meaningful market internationally over time. Very small study, it's really just to confirm that the clinical data from the US can be replicated in Japan; five centers, six patients, 180-day follow-up. We are halfway enrolled through this massive six patient trial. We anticipate enrollment will complete in the not too distant future, we'll then follow patients for six months and submit. And given the inefficiencies of the Japanese bureaucracy, we're anticipating sort of a 2016 approval in Japan. A study that's been interesting for us to get started or not quite get started is a thoracotomy study.

So as you can see in this image, a thoracotomy is a surgical technique where you make an incision in between the ribs, dilate the rib cage a little bit on the left side of the chest to implant the pump. Second incision in the center of the chest to connect the graft or anastomose the graft to the ascending aorta. Normally with other VADs, you have to do a full sternotomy through the center of the chest to expose the heart. So what thoracotomy has evolved to with probably 30% of our international implants being done by thoracotomy and nearly 20% of our US implants now done by thoracotomy, it's really demonstrated the benefits of having a smaller pump. So smaller pumps when we first launched, it was great because it was easier for the doctor to put in.

Now they're starting to realize it's not only easier, but it can also materially reduced the invasiveness of the implant, potentially reduce hospitalization, and potentially reduce right heart failure and bleeding, et cetera. And so it's converting size and ease of use into a clinical benefit versus a sort of ease of use surgical benefit. We're all set to move forward with an IDE to study thoracotomy, it's not in our label right now. We made the mistake of teaching doctors how to do sternotomies in our label so we had to then add an indication for thoracotomy, sort of lesson learned on our part. And the FDA contacted us and said well, you're already accumulating all this data on thoracotomy, have you thought about using that data instead of running a trial and then do a post-approval study.

So, we're currently waiting for the FDA to give us feedback on a proposal we have to use retrospective registry data that we already have in hand and then we would do a post-approval study specifically looking at thoracotomy. So, we still are keeping the IDE path alive, it would just be more efficient to get the label change early next year and then do a post-approval study so we'll see how that turns out. Our next generation pump, the MVAD, is one that we are quite enthusiastic about and is particularly attuned for thoracotomy because it is so small. It's only 22 CCs displaced

volume and I'll show you on a relative scale how small that is. It's capable of a broader range of support than even the HVAD so you can get full support, but you can also more easily turn it down to a liter or potentially even less.

And where that's interesting is for right heart support, for [less sick] patient support, for pediatrics where right now with HVAD, you can make it work, but you have to think about reducing the outflow graft and working harder whereas the MVAD can on its own cover that full range. It uses the same hydrodynamic and thrust bearing combination so passive suspension system just like the HVAD and you can see the two impellers, the silver one is the MVAD and the gold one is the HVAD. Obviously quite a different configuration albeit using the same design principles. It also has a steerable sewing ring, you can't really see in this picture, but the surgeons love the idea of being able to steer to the center of the ventricle field mix and feel like they have more control over the implant and outcome.

It also has the same very durable driveline although even thinner and we're looking forward to moving forward with our first in man in the not too distant future. In terms of our CE Mark trial design, we're looking at nine sites with 63 patients. They'll be followed for six months. We have done training for this trial although we have not yet submitted our documentation to the competent authority and [we're allowed] to do some additional training. We have been lectured by our surgeons that we had better let them do thoracotomy because this thing is so small, they won't be able to resist it so we will allow either sternotomy or thoracotomy. And I mentioned that sort of looking at the graphical difference.

In the right hand you can see the HVAD, that's the part that would be sticking outside of the heart and it may look big in this picture, but it's so much smaller than what everybody is used to. So when surgeons particularly look at what will be contacting the patient's pericardium in the MVAD, they're quite thrilled because they figure that will influence the inflow cannula even less than when combined with the steerable sewing ring. They're really optimistic about the potential benefits of this system in terms of just the surgical implant. What has the cardiologists even more enthusiastic is what we're seeing in terms of improved shear stresses with the system. So, this chart graph shows results of a test that we run to test the hemo compatibility or basically how the pump interfaces with the blood.

In this test, we used bovine blood and we put it through a loop essentially and run it through the impeller. And then in an hour, the blood will see the impeller 50 times more often than it would if it were in a patient or in a live animal because it's a closed loop and it just keeps seeing the impeller over and over again. Then every hour of tests, we take a sample of the blood to see how many red blood cells have been destroyed or hemolysis. And ordinarily what you see because it's in this closed loop, you see an aggregation of red blood cells, you have no kidneys filtering out the blood so you should see an aggregation. And that blue line on the vertical side on the right side of the chart shows the range of outcomes we see with other pumps we've tested.

The light blue line shows what we demonstrated with the HVAD, which also is a low shear system. And the orange lines are various MVADs in a new configuration of the impeller that we've tested. And then the control is basically a bag of blood where every hour we just siphon off blood to see how much hemolysis is naturally occurring in the static column of blood. When we started running these tests back in November and December, it frankly stunned us because this pump is spinning at 15,000 RPMs, it ought to be killing more blood cells. But our engineers had developed a lower shear impeller and we were hopeful we would see something like this although we didn't expect it would be this good.

For cardiologists this means theoretically, because it has to be proven, theoretically lower thromboembolic complications. Lower shear stresses on the blood may also reduce bleeding complications from Von Willebrands. If those two things are true, it also might mean lower anticoagulation requirements, which everybody would love. And so it appears to be one of those sort of rare all good or virtuous changes where we have not yet seen a trade-off. We thought there might be a trade-off in terms of our ability of magnetize this new impeller geometry, but so far it's been no problem whatsoever. So, we just can't wait to get this into people to prove which of these theoretical benefits come true.

The pump will be powered by a new controller, picture's here, we call it PAL or Peripherals for an Active Lifestyle. We've spent probably about a year now doing research with patients and coordinators and clinicians trying to understand what would they like to see in a next-generation set of peripheral equipment. So it has touch screen display, has a large battery on the inside that could run the pump for an hour so when you take the battery off, the controller can still run it while you're changing batteries. It has a snap-on battery instead of a cable so the patient only has one cable instead of three cables. The only cable being a driveline so much more esthetically attractive and certainly easier to manage for the patient. And there are a whole myriad of other benefits to this.

Anecdotally we just had eight patients at our facility on Monday and their caregivers and we showed them all our pumps and our whole pipeline and then we showed them this new controller. This is what everybody wanted and one of them said well, I also have a Finnish passport so if this gets approved in Finland before it gets approved in San Francisco, could I fly to Finland and get one of these so I can get rid of my current peripheral equipment. So, we haven't quite figured out how we're going to (inaudible). But for patients, they don't really care what a pump looks like because they never see the pump, they do care what the peripheral equipment looks like. And so, we're looking forward to seeing this in use in MVAD and then next year in HVAD.

The other large current project in our pipeline is a pump called SYNERGY. So, this is dramatically different than the MVAD or the HVAD both in terms of how it's implanted and the kind of patient that it's going to treat. SYNERGY came from a company called CircuLite, which we acquired in December. The pump is actually placed under the skin similar to a pacemaker on the right side so it still has a mini thoracotomy on the right side versus a thoracotomy on the left side. They treated about 100 patients and showed really impressive clinical results except that they also saw a cannulas fracture, which is a problem and they saw higher rate of pump thrombus than was really particularly attractive.

And yet what we saw when we were looking at the company was when it worked, when the pump didn't thrombus, it was fantastic. So as we looked at this system, we tried to figure out do we think we can fix the pump thrombus problem and we thought we could and can we fix the cannula problem and we thought that we could. So far the cannula fracture problem seems like yes, pretty easy to fix and the pump challenges also looks like we are on the right track. We've improved the washing tenfold compared to where it was before so they had sort of areas where the blood was static inside the pump and we've just cleaned that up with our pump designers. And are currently running some chronic animal studies, which appear not to have thrombus so far because they're still running and they're well on their way.

So by kind of end of the summer, we'll know if we are on the track with the thrombus and cannula fix question, which puts us on track where we want to be, which is by the end of the year to be able to sit down with the international regulators and say okay, we had a CE mark on the old design, what do you need to see on the new one to get it back on market. And we also have to think about what do we need to prove to our clinicians so that we can actually successfully commercialize it. Right now even if we get a CE mark on this version, we'd have sort of no evidence to support it other than their old data. So, we'll do some sort of clinical validation regardless of what the requirements are to return to market.

The pump changes will also be applied to the endovascular version. So take the same surgical implant, get rid of the thoracotomy and the inflow cannula can actually go through the subclavian vein through the right atrium to the left atrium. So, now it's a cardiologist with a little surgical assistance just to put the pump in, but it's mostly a cardiology procedure. If all goes well, this current surgical version gets back in the clinic next year. We confirm that we have fixed the pump and then the endovascular version sometime thereafter end of next year, beginning of the following year. We want to only test one variable at the time though so to prove that the pump is fixed before we go and put it in the endovascular version, which has yet to be used in people.

Because we go into less sick patients than our current MVAD and potentially in patients with preserved ejection fraction, which is also called diastolic heart failure which is about half the heart failure population, current VADs don't work for them though so it's a huge opportunity. We'll first validate it in the less sick systolic heart failure before we test it in the diastolic, but we're really increasingly convinced that there is a huge potential in that population. So, we feel really incredibly fortunate to have the pipeline that we're sitting on. I didn't even have time yet to talk about what's pictured on the right side with Longhorn or our implantable electronics, which we're also making very good strides on and we'll ultimately get rid of the driveline. So, that's sort of a luxury of riches that we're looking forward to seeing proved out in the clinic.

So all good news except last week we got a letter from the FDA, which was something I was like promising myself I would be the company that never got a warning letter; but we got a warning letter, which really did not make our day. And so having been at a prior company where we got a warning letter and brushed it off and said gee, it's no big deal, we'll take care of it in three months; I learned my lesson because it took them about like four years or something to get rid of it. So, that was a more severe warning letter than the one we got, but it is a sort of opportunity for us to either make light of it or make ourselves better. And so it's really actually been interesting over the past week since we got this letter to see how it has really steal the resolve of our team as we've recognized okay, we don't agree with everything in it, but we could do better.

And so we're bringing in substantial incremental resources. Obviously we didn't do everything right, let's bring in some objective observers to help teach us how to do things better, allocate the resources appropriately, and make sure we're focused on getting ourselves out of this predicament

and so far I like what I see very much. So, wish I didn't get the warning letter. On the other hand, it's kind of a growth opportunity for the Company. And as some people told us last week hey, congratulations, you're a real company, you just got your first warning letter. So I didn't really want to become a real company this way, but I guess we're a real company now. So despite the warning letter, we actually see very little change to our plans.

We get to keep shipping product, we are allowed to keep commercializing so not a meaningful change other than this now we have a new Number 1 priority, which is address those concerns of the FDA. But we're not seeing any impact on our US launch. We are doing an assessment just to make sure if the FDA didn't like some stuff we did with HVAD, let's make sure that we're not doing the same stuff they didn't like with MVAD. So, we're doing a bit of a step back and taking a breath, looking at all the work we did with MVAD to make sure we can do our first in man in Canada as planned and then submit for CE Mark. And we're not anticipating a meaningful impact to that timeline, but we do want to make sure that sort of once you're in a hole, don't keep digging. And so far, the thoroughness with which we have approached MVAD is night and day relative to how we approached HVAD way back when we designed that product.

We also look to complete our trial in Japan, either do the thoracotomy study or do the retrospective thoracotomy, one or the other. We didn't even talk about BiVAD. But with a small pump like HVAD and particularly MVAD, there's a lot of interest in doing a BiVAD trial so one on the left side, one on the right side; and we are looking forward to moving forward with that study later this year obviously. And then our supplemental cohort hopefully will get well on its way to either completing or nearly completing enrollment towards the end of this year and we've indicated it will probably be early next year that we'll get there. And we talked about SYNERGY. So, busy the year and we're making great strides on all these things. We just layered on an extra goal for the year or the FDA to give us an extra goal for the year.

So with that, I appreciate all your time and attention. And I think I have 4 minutes and 39 seconds, Matt.

Matt O'Brien - *William Blair & Co. - Analyst*

Maybe we'll take one question on the webcast.

QUESTIONS AND ANSWERS

Unidentified Audience Member

(inaudible - microphone inaccessible)

Doug Godshall - *HeartWare International, Inc. - Executive Director, President & CEO*

The supplemental trial is when we enrolled our bridge trial and our Destination Trial and we looked retrospectively at our data. We do this huge multivariate analysis to look at sort of major complications; sort of what are the risk factors for pump thrombus, what are the risk factors for stroke. And what jumped out at us particularly out of the bridge-to-transplant data was patients who had higher arterial pressures had a 14 times higher risk of stroke than patients who had lower blood pressures. And we've been working for a while to try to figure out how do we bring down our neurologic event rate, particularly the significant strokes.

So, it's all well and good to say okay, retrospectively we observe these things, but you kind of want to prove it prospectively. So, the second cohort is a one-year follow up instead of a two-year follow-up. We're [two to one] randomization HVAD versus HeartMate II looking at neurologic events and pump exchanges basically. And the big changes are a little bit of a modification on anticoagulation, but primarily a modification around blood pressure management where we're anticipating to see a meaningful reduction in neurologic events. We'll then consolidate that one-year follow-up data with our two-year follow-up data from the first cohort for our PMA is our current plan.

Matt O'Brien - *William Blair & Co. - Analyst*

Okay. Thank you all. We'll cut off the webcast now. Thanks.